Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SIMMEDS, INC

Respondent Name
TECHNOLOGY INSURANCE CO

MFDR Tracking Number
M4-11-3129-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
MAY 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is not a TENS unit. It is a neuromuscular stim which is ODG approved and under 500.00 and does not require preauth."

Amount in Dispute: $455.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier denied the services of 10/14/2010, E0745, $450.00 based on 'services outside of ODG require preauthorization'. Prior to denying this service, a review was done to determine if the services were within the ODG. Based on the review, the claimant would not qualify for this service, based on the ODG. The provider did not request any prior authorization for this service…The Carrier contends that the claimant did nto meet the criteria for this service, and the provider, who is aware of the ODG, did not seek prior approval."

Response Submitted by: AmTrust North America

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2010	HCPCS Code E0745 Neuromuscular Stimulator	$455.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006,requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197-Precertification/authorization/notification absent.
   - 851-008-Payment disallowed: Lack of authorization: No audhtorization given for service rendered.
   - 851-047-No additional reimbursement allowed after review of appeal/reconsideration.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the disputed neuromuscular stimulator require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

The requestor billed HCPCS code E0745 for the diagnosis 847.2-lumbar sprain/strain.

According to the Low Back Chapter of the Official Disability Guidelines (ODG), a neuromuscular stimulator is not recommended treatment for a lumbar sprain/strain; therefore, the disputed neuromuscular stimulator required preauthorization.

There is no evidence submitted, that the requestor obtained preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(12). As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/13/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.